
7BR Part-Heard!

Reiss Palmer: Hello, and welcome to 7BR Part-Heard, the podcast that traverses the legal landscape, examining issues across multiple practice areas guided by the diverse expertise of our members.

I'm Reiss Palmer, Chambers, Paralegal.

We're joined today by 7BR member Leslie Keegan. Leslie specialises in clinical negligence, medical law, personal injury and cases involving abuse of those in care. Leslie is an acknowledged expert in quantum, particularly in very high value claims, and combines robust advocacy with widely acknowledged client care skills, and an in depth knowledge of law. Experience includes catastrophic brain injury arising from trauma or from hypoxia, and a wide variety of clinical negligence and personal injury cases. Over the past 15 years, he has organized the highly regarded 7BR Skeleton Series, which is a six week series of medicolegal lectures.

In this podcast, he deals with functional neurological disorder cases with reference to two recent cases involving large settlements on behalf of clients suffering with functional neurological disorders.

Leslie, welcome to the podcast.

Leslie Keegan: Thank you.

Reiss: So we're here today to talk about functional neurological disorder. But, before we begin, I think it's always important just to start with the basics. What is functional neurological disorder?

Leslie: Well Reiss, I rely obviously on medical experts to tell us about these disorders. So, I'm looking at it through the medicolegal prism. This term, in essence, describes a problem with the functioning of the nervous system in a structurally normal brain. So we have to keep that in mind that the structure is generally normal, but it's the **function** that's not working quite well. What we see in many of these cases that although the movement or the sensory aspects of an arm, a leg or whatever, can be affected by this functional condition, then, actually, when the nerve pathways are looked at either by motor or sensory nerve testing, they are conducting normally. They're all intact, and they appear to be operating normally. So, if you pass an impulse along the nerve, everything looks fine. You can have similar problems with the brain. You can examine the structure in a variety of ways with neuroradiological imaging and see that the brain is structurally normal, but still, the patient, for some reason, is not functioning correctly.

Reiss: And why is it important for us to consider this?

Leslie: Well, why I think it's important for us to consider it is: a functional neurological disorder can have a devastating effect on somebody's life. There is, as I've said, an absence of easy evidence to support these disorders, and there's a general suspicion nowadays that clients or patients may be just trying it on and people saying, well, look, there's no change on a particular test, there's no change on that scan, and therefore, they're sort of trying it on. And it also occurs against this growing narrative or suspicion, that claimants are exaggerating or making up/feigning symptoms. Therefore, it's important for us to listen carefully to the client, to go to the family for support of factual evidence, and to really press our experts, the neurologists, the neuropsychiatrist, the neuroradiologists, or whoever the experts are in the case to try to seek an explanation for the symptoms. That's not to say that we just blindly accept what a

client is saying as being absolutely true, but we must carefully examine it, and we have to look for as much evidence as possible in support of what the client or patient is complaining about.

It's also important to remember that, as in the cases I will be talking about today, that just because we become disappointed when there's not an **obvious**, or **easy** explanation for what appears to be a serious neurological disorder or malfunction, that we don't just abandon it. That's the time when we should redouble our efforts to gather the evidence in support, and there are also in these cases and I'm speaking as a lawyer, because the sort of cases we see, there's often been an injury, and therefore, there's often pre-existing problems, sometimes physical, sometimes psychological, and that shouldn't deter us from going all out to make as much effort as possible to put aside whatever was happening before in terms of the physical or the psychological difficulties, and to make sure that we are looking carefully, and very carefully, at what the evidence is.

Reiss: What are the sort of main reasons why people develop functional neurological disorder. I know that you mentioned that most of your time that you're dealing with this, it's coming from accidents.

Leslie: Well, the reasons why, people develop functional neurological disorders are multifactorial, and they're complicated. They tend to happen when the brain has difficulty coping with thoughts, memories, emotions, sensations, or some sort of physical injury or insult. They can be associated with stress, but that's not always the case. The development of functional symptoms may be related to things that people have little or no control of, can be something like the loss of a loved one, relationship difficulties, or trauma of some kind. And as I've said, it also occurs in the cases that we, as lawyers see, where there is an injury. I'll be talking about two particular cases today in relation to that.

But a functional neurological disorder, it's a descriptive rather than an explanatory diagnosis. There's not an easy explanation for what you're seeing. People have these neurological-like symptoms and there's an absence of evidence of a structural abnormality, and sometimes the **extent of the impairment or the disability** is greater or even much greater than could reasonably be explained by the known organic pathology or structural abnormality that we see.

Reiss: What sort of symptoms and I know you've been mentioning them a bit now, but what sort of symptoms do we see?

Leslie: Well, the sort of symptoms that we see are in changes in the way the brain processes information. So, it can be changes in the way that it's dealing with sensory information. We can have abnormalities in the link between the brain planning a movement, and it being carried out, sometimes called the motor movements, if you like. But we also see symptoms of difficulty with concentration, memory, and fatigue, and difficulties with seizures, with people blacking out, losing consciousness, with or without seizures. And when I talk about the sensory symptoms, you get people who can't feel things properly, touch, etc. or positive symptoms like they're experiencing pins and needles. And a common sensory symptom is pain. It's pain that's difficult to locate and sometimes can get better or worse, depending on tiredness or fatigue. The motor symptoms are sometimes twitches, tremors, people have difficulty in moving, difficulty with walking, difficulty with their gaits, and can have a huge effect on people. And then we also see difficulties with concentration, memory, fatigue, and people often complain about difficulties with concentration, difficulties with memory problems. And as I've referred to also, the fourth area of symptoms is people losing

consciousness with or without seizures which can have a huge effect on people's lives. So it's very important to keep in mind in these cases that there's a need to explore the possible physical causes for the deficit or the symptoms that we're seeing, but when there's an absence of a physical explanation or an easy physical explanation, then we must explore the psychology and the psychiatry, and I would suggest, as a claimant lawyer, that defendants are too quick to say, well, there's no physical explanation, therefore, they're putting it on, and therefore, the defendants say, oh, they're just feigning symptoms, or sometimes the defendants say, oh, well, this is just really the pre-existing difficulties that we're seeing.

Reiss: Well, you've given us quite a background as to what functional neurological disorders are. And I know that you mentioned that you wanted to talk about some of the cases today, so perhaps we can now move towards that and see how this actually comes to light in practice from your experience.

Leslie: Well, the first case that I wanted to talk about was a case of somebody who was already vulnerable. She had an epileptic seizure and had a history of epileptic seizures. But on this occasion, when she suffered an epileptic seizure, she rolled onto a hot water bottle in the bed, causing her to be scalded. So, she had a significant physical injury because it was a very significant scald, and she required skin grafting. And following the skin grafting surgery and the difficulties that she had, she required opiates to deal with the pain. Now, here's where things really started to go wrong, because, unfortunately, the administration of the opiates wasn't managed appropriately. She was given too much morphine, and, of course, too much morphine will depress somebody's respiratory rate.

Our argument was that the depressed respiratory rate led to decreased oxygen to her brain, causing some degree of brain damage. And here, like in the other case that I'll be talking about, we had an easy or an obvious pathway, which the medics were quite happy looking at initially and saying, well, there was a decreased respiratory rate, decreased supply of oxygen to the brain, death of brain tissue, and the medics got excited because there was the obvious explanation, the obvious possibility of the decreased oxygen to the brain causing structural brain damage.

But I mentioned that already, here, we had the pre-existing problems. Well, she had the pre-existing epilepsy and, unfortunately, ten years earlier, in 2007, there was an attempt to implant electrodes into her brain to control her epilepsy. She also had depression along with the epilepsy, and then the surgery for her epilepsy went wrong and she suffered a stroke resulting in hemiparesis. So, she already had loss of movement on one side. The neuropsychologists had agreed that she was fairly limited in her activities prior to this event, and that made determining what the decline was from a low baseline, challenging. They also accepted that she had long-standing challenges in relation to her mood, with many episodes of depression throughout her life. But they disagreed, as you might imagine, about the extent of the effect of these events on her. So, there was a difference between the neuropsychologist for the claimant and the neuropsychologist for the defendant.

The neurologists stated that there was evidence from the GP records that her epilepsy was difficult to control. There were multiple entries of difficulties over a period between 1991-1995, and evidence of about 20 changes to her epilepsy medication in order to try and control that. So there was great difficulty in controlling her seizures. And as I said, she had this hemiparesis, the loss of movement sensation down one side and she had difficulties which existed prior to this overdose of morphine.

The neuroradiologist carried out some examination and, unfortunately, the neuroradiology didn't show any conclusive images which indicated evidence of an injury due to this overdose of morphine. But, it's always worth remembering that neuroradiology doesn't always provide conclusive evidence. It's limited in terms of resolving what impacts that can be seen. When abnormalities are seen that is good evidence, obviously of structural damage. But when they are not seen, it doesn't mean that there is no damage. It can be that there may be structural changes present which cannot be seen or that there are no structural changes at all.

Experts will tell us that brain damage dysfunction that affects neuropsychological function can, and does often occur, and can't be seen on routine clinical imaging.

The neuropsychologists in this case highlighted the difficulties, because the difficulties, as I said, were that you're starting from a low baseline and it was difficult to work out what effect it had on her functioning. But there was some change and our neuropsychologist was adamant about this, there was changes that could be seen on testing in our orientation, in our memory functioning and in our language functioning. Although still accepting that there were these pre-existing difficulties, our neuropsychologist said, well, there was cognitive decline and you could see that. Although our neuropsychologist accepted that, well, the defendant's neuropsychologist went for the usual sort of easy answer, well, there was a lack of effort on her part is what was said, she already had the depression and anxiety. She already had pain. She already had epilepsy. She already had sleep disturbance and there wasn't, therefore, a great deal of change, and in any event, the change could be attributed to these pre-existing difficulties.

What's important here was the factual witness evidence as well. We went back to her partner and to her son, and they were able to give clear evidence and consistent evidence about the changes that they could see in the claimant, following the overdose of morphine. And what we had was that overall, although there were pre-existing difficulties there was evidence of harm. There was a mechanism whereby she could have suffered a physical injury, and although when we explored it with the neuroradiologist, there wasn't evidence on the scans and there wasn't evidence in relation to the neurology. What there was, was a neuropsychologist who was supportive of these changes and of this radical change in the claimant, and we had good evidence from the partner and her son, and therefore, what we were able to do was to say, well, this is, and looks like a distinct functional neurological disorder, and thankfully, we were able to get a settlement for the claimant, which was approved by the High Court, and that was in the sum of £200,000. So, by just going back, considering the evidence and pressing everybody to look carefully at it and saying, well, although there isn't this ready explanation that we thought there might be and the medics that was at the outset, nevertheless, there is evidence of a decline and she was compensated for that decline.

Reiss: Now, just moving to the second case, could you just give us an overview of how that was different from the first case and what was important in terms of FND there?

Leslie: Well, this case second case involved a bile leak and really a post-surgical infection, a prolonged stay in hospital, but not the sort of case where you usually see somebody going from a high level of functioning, which this client was, in a responsible job, to somebody who had fatigue, a variety of physical problems, including problems with her gait, slurring of her speech when she was tired, and long term impairment of her neuropsychological functioning, which resulted in her having to give up her job, and in requiring some care and assistance with personal and domestic tasks.

The surgery itself, as I said, was very straightforward. It was laparoscopic surgery for removal of the gallbladder and the surgery went well, but she suffered from a bile leak following the surgery. This went unnoticed for a few days and even when it was noted, it took another few days for them to carry out, to scan and to confirm it and to treat her appropriately. The general surgery experts agreed that the delay in diagnosing the bile leak and the failure to give prophylactic antibiotics when carrying out that procedure to repair it, led to a slightly longer stay in hospital and a discrete period of pain and suffering, due to mild pancreatitis following the initial operation when she had this undiagnosed bile leak.

However, as I said, this claimant suffered huge consequences as a result of this, and the greater concern was not, obviously, the pancreatitis, it was whether she suffered some brain damage as a result of the bile leak and the sepsis, because there was a radical change in her ability to function. She went from this high level of functioning to somebody with a number of the physical and psychological issues, and as I said, who needs great help with a lot of functioning. And she had fatigue problems, concentration problems, problems with walking due to changes in her gait.

Now, what was the possible route here? Well, there was a ready explanation here, because, firstly, our neurologist said, well, the claimant's symptoms were some of the sorts of symptoms that you can see following organic or structural brain damage, that is, changes in cognitive problems and the fatigue and so on. The neuroradiology didn't strongly suggest that she had structural damage either. And again, the neuropsychologist said, well, just because there's not neuroradiological evidence, you have to appreciate that the absence of any structural brain damage doesn't prove that there's no damage or dysfunction in affecting her brain. But the possible route that they were suggesting, and that is the surgeons and the neuropsychologists and so on, was that she had developed an infection, which she had, that the infection caused sepsis, which she had some degree of sepsis. But here the sepsis became so severe that it led to septic shock. And septic shock can cause a decrease in blood pressure and can deprive vital organs, such as the brain, of blood. And they were saying, I think that's probably what we're looking at here, but you need to go and ask the microbiologists in relation to it. But the microbiologist said, "no", the infection was never that severe to cause septic shock. So, what we had was a possibility of the infection causing the septic shock, but the experts in the field, the microbiologists, are saying, no, it's not, we can't support it being severe enough. And what was eventually agreed by the neuropsychologist was that even though she had difficulty in engaging with testing, that she had evidence of a decline in functioning, they said that she had some post-traumatic stress disorder caused by these events, by what happened to her, by the difficulties after the surgery. And she developed functional neurological symptoms, which include the slurred speech, the confusion, the word finding difficulties, and the short term memory difficulties, in addition to some symptoms of PTSD, including anxiety, sleep disturbance and so on. They also agreed that she presented with chronic fatigue with intense physical and mental fatigue on small physical or mental exertion.

There was a large measure of agreement between the experts in their respective disciplines that it was the failure to identify and treat the bile leak that occurred, caused *some* physical problems in the form of mild pancreatitis but that it didn't cause structural brain damage, - but that it caused a functional neurological disorder which had significant effects on the ability of the claimant to function. I say, again, although there could have been an obvious route and a ready explanation for this by way of the sepsis, that wasn't there, and what we had was somebody who had real problems and they were real, they were completely honest, as the claimant was, and supported by her partner, who gave very good evidence about this. So, we had a devastating effect on her life, and she continues to have these

difficulties with gait, with speech, with concentration, with fatigue and requires a lot of assistance. And that's why we were able, finally, to settle the case at a joint settlement meeting for £775,000, which reflects the huge effect that this functional neurological disorder had on this woman's life. It was real and it is real.

Reiss: So taking the cases that you've just discussed and sort of functional neurological disorder as a whole, are there any lessons that we can take from this, any lessons to learned?

Leslie: Yes, I think there is. I think that what we have to realise is that functional neurological disorder is very real and can sometimes be a devastating condition. And it is occurring, as I've indicated at the outset, against a growing narrative or suspicion that claimants are exaggerating or indeed feigning symptoms.

Therefore, it's particularly important for us to listen carefully to the client, to go back to the family for support of factual evidence and to press our experts, the neurologist, the neuropsychiatrist, the neuroradiologist, to seek an explanation for the symptoms. It's not to say, as I've said previously, that we just blindly accept what the client is saying as being absolutely true, but we must carefully examine it and look for as much evidence as possible in support.

And it's particularly important in these cases to remind defendants that if the case is looking like it might be a functional neurological disorder case, then it is important to get therapy in place as soon as possible, because in the last case that I talked about, one of the things which was difficult and particularly difficult for the defendant to accept, was that the experts, the neuropsychologist and neuropsychiatrist, agreed that because this had been an established condition for a period of, in this case, four plus years, that it was unlikely that even with appropriate therapy, that her condition could be improved.

So the lessons that I say is that we *must* listen to the client, we *must* press as much as possible to find evidence, and even if there isn't a ready explanation, we *must* carry on looking until we can be fully satisfied that it either is or isn't a functional neurological disorder.

Reiss: Thank you, Leslie. It's been a pleasure having you on today.

Leslie: Thank you.

Reiss: Thank you to our listeners. We hope you enjoyed this week's episode of Part-Hard and Leslie's discussion and analysis of functional neurological disorder. You can find all our previous episodes from our members on Chambers' website and all major streaming platforms until next time. Thank you and goodbye.

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